Secondary Diabetes Prevention: A Partnership with Public Health: Seattle & King County

- **Karen Winston, Aging and Disability Services**
- **Patricia Manuel, MS, RD - Public Health: Seattle & King County**

Aging and Disability Services

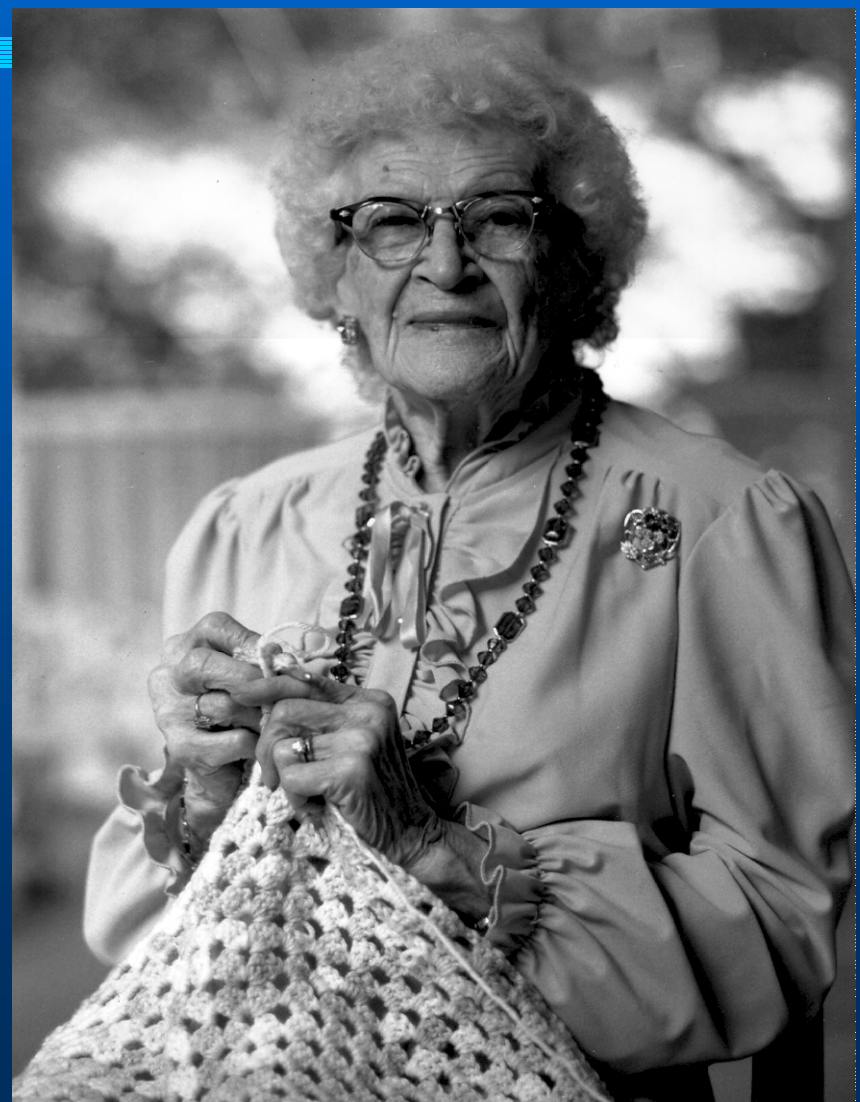
- **Mission -** To develop a community that promotes independence and choice for older people and adults with disabilities in King County.
- **2000 budget**: $32.5 million of federal, state, and local resources.
- **19 Service Areas**: Ranging from Adult Day to Nutrition, and Transportation.

ADS Area Plan on Aging

- A four year planning document that highlights goals and levels of service for older adults in King County.
- Area Plan Focus (2000-03)
  - Home Care Quality
  - Healthy Aging
  - Long Term Care
  - Housing
  - Caregivers Support

ADS Diabetes Objective

- **Healthy Aging:**
  To increase by 5% the number of case management clients diagnosed with diabetes whose diabetes is under control (by December 2003).



Healthy Eating for Healthy Aging

- **Program within Public Health: Seattle & King County, Chronic Disease Prevention and Healthy Aging Unit.**
- **Funding matched through WA State Department of Health and DHHS Food Stamp Nutrition Education.**

Healthy Eating Healthy Aging: Goals

- **To help middle aged adults and seniors who are struggling to feed themselves in a healthy way on a limited budget.**
- **To reduce racial and ethnic disparities of disease, especially diabetes, among low income middle-aged adults and seniors.**

Healthy Eating for Healthy Aging

- **Scope of Work:**
  - cooking / tasting food demonstrations
  - systems change for diabetes clients
  - medical nutrition therapy for homebound clients
  - nutrition screening for seniors
  - coordinate a King County Senior Nutrition Forum
  - train students and professionals to work with low- income seniors

King County Diabetes Demographics

- **Diabetes: Focus of PHSKC 11/99 Data Watch.**
- **Diabetes is the 7th leading cause of death in King County.**
- **About 66,000 King County adult residents have diabetes.**
- **The diabetes death rate in King County has increased 50% since the mid-1980's.**

King County Diabetes Demographics

- **The risk of diabetes increases with age.**
- **The rates of hospitalization and death also increase with age.**
- **The prevalence of and death rates for diabetes in African Americans, Native Americans, and Hispanics are substantially higher than whites.**

ADS: The Work Group

- ADS Case Management Program
- Public Health: Seattle & King County
- American Diabetes Association
- WA State Dept of Health - Diabetes Control Program
- Asian Counseling & Referral Service
- Chinese Information & Service Center
- Evergreen Care Network

ADS: The Work Plan

- **Establish baseline data and diabetic registry.**
- **Identify the target intervention group.**
- **Develop intervention strategies.**
- **Train case management staff to provide intervention strategies.**
- **Pilot project implementation.**

ADS: The Registry Components

- Name
- Identification Number
- Gender
- Race/Ethnicity
- Language (Interpreter)
- Date of Birth
- Address and Phone
- Primary Care Physician
- Name of Insurance
- Weight and Height (BMI)
- Date/Year of Diagnosis
- Hx HGB-A1C (Value, date, normal range
- Does client monitor blood glucose?
- Medications (Insulin, Oral, other)
- Smoking
- Interventions (1, 2, 3, etc.)

Diabetes Objective: Current Status

- **Received $12,000 from in-house Supplemental Funding for 2000.**
- **Working to establish the database:**
  - Identifying clients with diabetes.
  - Contacting them re: their participation and client consent form.
  - Contacting the health care provider for information on each client.

Diabetes Objective: Current Status

- **Healthy Eating for Healthy Aging funded for 2001:**
  - **Home visits to provide Medical Nutrition Therapy for 75 seniors or disabled adults with diabetes through Aging and Disability Services Case Management.**

Diabetes Objective: Current Status

- **REACH: Racial and Ethnic Approaches to Community Health, CDC funding to reduce racial and ethnic disparities in health, specifically diabetes**
  - Overall community will receive interventions
  - Possibility of direct funding for case management

Modifiable Risk Factors

- Obesity
- Physical inactivity
- Poor nutrition and lack of access to food
- Lack of knowledge about diabetes
- Lack of awareness of having diabetes
- Lack of resources to manage diabetes
- Inadequate medical care

Planned Intervention Strategies

- **Medical Nutrition Therapy**
- **Physical Activity**
- **Medication Management**
- **Appropriate Preventive Measures (blood, eyes, feet, etc.)**

Value of Partnership

- **To Aging and Disability Services:**
  - Addresses mission statement.
  - Introduces health and preventive care to case management program.
- **To Public Health: Seattle & King Co.:**
  - Addresses goals of Healthy Eating for Healthy Aging
  - Addresses goal of REACH

Everyone can be great because everyone can serve. All it takes is a heart full of grace and a soul that generates love.

Martin Luther King, Jr.